		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0033324

Facility Name: Manorcare at Palos Heights

Address: 7850 West College Dr. (Number) Palos Heights (City) 60463 (Zip Code)

County: Cook

Telephone Number: (708)361-6990 **Fax #** (708)361-7697

IDPA ID Number: 520886946013

Date of Initial License for Current Owners: 06/02/88

Type of Ownership:

[ ] VOLUNTARY,NON-PROFIT		[X] PROPRIETARY		[ ] GOVERNMENTAL	
	[ ] Charitable Corp.		[ ] Individual		[ ] State
	[ ] Trust		[ ] Partnership		[ ] County
IRS Exemption Code			[X] Corporation		[ ] Other
			["Sub-S" Corp.		
			[ ] Limited Liability Co.		
			[ ] Trust		
			[ ] Other		

In the event there are further questions about this report, please contact:
Name: Gary Geise **Telephone Number:** (419)252-5731

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/00 to 05/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Barry Lazarus

(Title) Vice President - Director of Reimbursement

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Manorcare at Palos Heights # 0033324 Report Period Beginning: 06/01/00 Ending: 05/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,750	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	30	Sheltered Care (SC)	30	10,950	5
6		ICF/DD 16 or Less			6
7	180	TOTALS	180	65,700	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,847	3,901	11,975	19,723	8
9	SNF/PED					9
10	ICF	12,541	17,969	699	31,209	10
11	ICF/DD					11
12	SC		8,315		8,315	12
13	DD 16 OR LESS					13
14	TOTALS	16,388	30,185	12,674	59,247	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.18%

D. How many bed-hold days during this year were paid by Public Aid?
197 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/02/88

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 60 and days of care provided 9,753

Medicare Intermediary CareFirst of Maryland, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31/01 Fiscal Year: 05/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Manorcare at Palos Heights # 0033324 Report Period Beginning: 06/01/00 Ending: 05/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	327,272	40,474	831	368,577	2,197	370,774		370,774			1
2	Food Purchase		228,637		228,637		228,637	(318)	228,319			2
3	Housekeeping	137,383	17,449		154,832		154,832		154,832			3
4	Laundry	47,320	18,278	936	66,534		66,534		66,534			4
5	Heat and Other Utilities			160,098	160,098	10,073	170,171		170,171			5
6	Maintenance	47,945	43,044	63,445	154,434		154,434		154,434			6
7	Other (specify):*											7
8	**TOTAL General Services**	559,920	347,882	225,310	1,133,112	12,270	1,145,382	(318)	1,145,064			8
	B. Health Care and Programs											
9	Medical Director			18,200	18,200		18,200		18,200			9
10	Nursing and Medical Records	2,336,289	184,220	8,311	2,528,820	39,813	2,568,633		2,568,633			10
10a	Therapy	296,250	762	60,730	357,742		357,742		357,742			10a
11	Activities	88,414	5,690	60	94,164		94,164		94,164			11
12	Social Services	29,066			29,066		29,066		29,066			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,750,019	190,672	87,301	3,027,992	39,813	3,067,805		3,067,805			16
	C. General Administration											
17	Administrative	70,697		683,379	754,076	(328,660)	425,416		425,416			17
18	Directors Fees											18
19	Professional Services			1,506	1,506	(1,506)						19
20	Dues, Fees, Subscriptions & Promotions			63,028	63,028		63,028	(32,639)	30,389			20
21	Clerical & General Office Expenses	243,373	50,319	7,876	301,568	1,506	303,074	49,668	352,742			21
22	Employee Benefits & Payroll Taxes			669,193	669,193	(21,070)	648,123		648,123			22
23	Inservice Training & Education			568	568		568		568			23
24	Travel and Seminar			3,382	3,382		3,382		3,382			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			48,191	48,191		48,191		48,191			26
27	Other (specify):* Personal Purchases			979	979		979	(979)				27
28	**TOTAL General Administration**	314,070	50,319	1,478,102	1,842,491	(349,730)	1,492,761	16,050	1,508,811			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,624,009	588,873	1,790,713	6,003,595	(297,647)	5,705,948	15,732	5,721,680			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Manorcare at Palos Heights #0033324 Report Period Beginning: 06/01/00 Ending: 05/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			373,276	373,276	54,516	427,792		427,792			30
31	Amortization of Pre-Op. & Org.			33,682	33,682		33,682		33,682			31
32	Interest					243,131	243,131		243,131			32
33	Real Estate Taxes			208,762	208,762		208,762		208,762			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			21,879	21,879		21,879		21,879			35
36	Other (specify):*											36
37	**TOTAL Ownership**			637,599	637,599	297,647	935,246		935,246			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		211,947	42,647	254,594		254,594		254,594			39
40	Barber and Beauty Shops			41,526	41,526		41,526		41,526			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,125	82,125		82,125		82,125			42
43	Other (specify):* **IV Drugs**			86,953	86,953		86,953		86,953			43
44	**TOTAL Special Cost Centers**		211,947	253,251	465,198		465,198		465,198			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,624,009	800,820	2,681,563	7,106,392		7,106,392	15,732	7,122,124			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Manorcare at Palos Heights # 0033324 Report Period Beginning: 06/01/00 Ending: 05/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(318)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,165)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(979)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	52,825	21		24
25	Fund Raising, Advertising and Promotional	(32,639)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Vending Inc. & Misc.	(1,992)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 15,732		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 15,732		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Manorcare at Palos Heights

ID# **0033324**

Report Period Beginning: **06/01/00**

Ending: **05/31/01**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at Palos Heights # 0033324 **Report Period Beginning:** 06/01/00 **Ending:** 05/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(318)	0	0	0	0	0	0	0	0	0	0	(318)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(318)	0	0	0	0	0	0	0	0	0	0	(318)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(32,639)	0	0	0	0	0	0	0	0	0	0	(32,639)	20
21	Clerical & General Office Expenses	49,668	0	0	0	0	0	0	0	0	0	0	49,668	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(979)	0	0	0	0	0	0	0	0	0	0	(979)	27
28	**TOTAL General Administration**	16,050	0	0	0	0	0	0	0	0	0	0	16,050	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	15,732	0	0	0	0	0	0	0	0	0	0	15,732	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Manorcare at Palos Heights # 0033324 **Report Period Beginning:** 06/01/00 **Ending:** 05/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	15,732	0	0	0	0	0	0	0	0	0	0	15,732	45

Facility Name & ID Number Manorcare at Palos Heights # 0033324 Report Period Beginning: 06/01/00 Ending: 05/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ManorCare, Inc.	100	Health Care & Retirement Corporation of America (SEE H.O. COST REPORT)				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		See Page 8	Home Office Allocation	$ 683,379	HCR ManorCare, Inc.	100.00%	$ 683,379	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V		10a	Therapy Management	26,500	Heartland Management Services	100.00%	26,500		6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 709,879			$ 709,879	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Manorcare at Palos Heights # 0033324 Report Period Beginning: 06/01/00 Ending: 05/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Manorcare at Palos Heights # 0033324 Report Period Beginning: 06/01/00 Ending: 05/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR ManorCare, Inc.
Street Address: 333 North Summit St.
City / State / Zip Code: Toledo, OH 43604
Phone Number: (419) 252-5500
Fax Number: (419) 254-5495

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	1,816,305,362	357 Nurs. Fac.	$	$		$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,066,722,869	357 Nurs. Fac.	671,002	407,536	6,767,413	2,197	2
3	5	Utilities - Direct	Accumulated Cost	1,816,305,362	357 Nurs. Fac.	262,823		6,767,413	979	3
4	5	Utilities - Pooled	Accumulated Cost	2,066,722,869	357 Nurs. Fac.	2,777,349		6,767,413	9,094	4
5	10	Nursing - Direct	Accumulated Cost	1,816,305,362	357 Nurs. Fac.	6,096,791	4,282,378	6,767,413	22,716	5
6	10	Nursing - Pooled	Accumulated Cost	2,066,722,869	357 Nurs. Fac.	5,221,432	3,383,186	6,767,413	17,097	6
7	17	General & Admin. - Direct	Accumulated Cost	1,816,305,362	357 Nurs. Fac.	23,025,730	19,694,773	6,767,413	85,792	7
8	17	General & Admin. - Pooled	Accumulated Cost	2,066,722,869	357 Nurs. Fac.	82,128,599	31,955,235	6,767,413	268,927	8
9	22	Employees Benefits - Direct	Accumulated Cost	1,816,305,362	357 Nurs. Fac.	2,724,065		6,767,413	10,150	9
10	22	Employees Benefits - Pooled	Accumulated Cost	2,066,722,869	357 Nurs. Fac.	(9,534,453)		6,767,413	(31,220)	10
11	30	Depreciation - Direct	Accumulated Cost	1,816,305,362	357 Nurs. Fac.	74,480		6,767,413	278	11
12	30	Depreciation - Pooled	Accumulated Cost	2,066,722,869	357 Nurs. Fac.	16,563,680		6,767,413	54,238	12
13										13
14	32	Interest		0		14,161,817			243,131	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 144,173,315	$ 59,723,108		$ 683,379	25

Facility Name & ID Number Manorcare at Palos Heights # 0033324 Report Period Beginning: 06/01/00 Ending: 05/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Conv. Sub. Debentures		X	Facility			$ 3,102,852	$ 3,102,852			$ 243,131	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 3,102,852	$ 3,102,852			$ 243,131	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,102,852	$ 3,102,852			$ 243,131	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Manorcare at Palos Heights # 0033324 Report Period Beginning: 06/01/00 Ending: 05/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	668,325	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	564,485	2
3. Under or (over) accrual (line 2 minus line 1).	$	(103,840)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	312,602	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	208,762	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	415,345	8
	1997	427,468	9
	1998	435,796	10
	1999	343,018	11
	2000	337,948	12

Line 2 = $168,974 for 1st half 2000 + $343,018 for 1999 + $52,492 adjustment for prior year.
Line 4 = $312,602 (168,974 for 2nd half of 2000 + 143,628 for Jan-May 2001)
Line 12 is an estimate from the 1st half of 2000 tax bill, final 2000 tax bill not received yet.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare at Palos Heights COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0033324

CONTACT PERSON REGARDING THIS REPORT Gary Geise

TELEPHONE (419)252-5731 FAX #: (419)252-5548

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	23-24-300-330-0000	See attached	$ 469,895.58	$ 337,948.90
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 469,895.58	$ 337,948.90

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Manorcare at Palos Heights # 0033324 Report Period Beginning: 06/01/00 Ending: 05/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,391 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		1988	$ 600,191	1
2					2
3	TOTALS			$ 600,191	3

Facility Name & ID Number Manorcare at Palos Heights # 0033324 Report Period Beginning: 06/01/00 Ending: 05/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150			1988	$ 4,355,326	$ 133,525		$ 133,525	$	$ 1,663,840	4
5	30			1990	1,063,606						5
6				1990	(10,000)						6
7											7
8											8
	Improvement Type**										
9	CURRENT YEAR DEPRECIATION					148,692		148,692		971,239	9
10				1988	203,173						10
11				1989	47,755						11
12				1990	43,288						12
13				1991	135,227						13
14				1992	55,270						14
15				1993	67,665						15
16				1994	68,557						16
17				1995	133,690						17
18				1996	183,199						18
19				1997	242,019						19
20	ELECTRICAL WORK			1998	14,550						20
21	FLOORING/CEILING			1998	6,151						21
22	REPLACE DOORS/WINDOWS			1998	7,412						22
23	HVAC			1998	9,639						23
24	GENERAL CONTRACTOR FEES			1998	15,798						24
25	INSTALL METAL FASCIA			1998	5,000						25
26	DEMOLITION/FINISH STUD			1998	30,000						26
27	WALLVINYL			1998	5,683						27
28	CORPORATE OVERHEAD			1998	1,651						28
29	PROFESSIONAL FEES			1998	2,182						29
30	PAINTING/WALLCOVERING			1998	29,656						30
31	ELECTRICAL			1998	4,430						31
32	DEVELOPERS			1998	5,555						32
33	HVAC			1998	5,465						33
34	DOOR/WINDOW			1998	8,650						34
35	SIGN			1998	11,862						35
36	MASONARY			1998	4,323						36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare at Palos Heights # 0033324 Report Period Beginning: 06/01/00 Ending: 05/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	CARPENTRY	1998	$ 12,052	$		$	$	$	37
38	MILLWORK	1998	23,700						38
39	FINISH STUDS	1998	2,135						39
40	GENERAL CONTRACTOR FEES (CORRECTS LINE 24, PG 12)	1998	(1,337)						40
41	PROFESSIONAL SERVIES (CORRECTS LINE 29, PG 12)	1998	(1,091)						41
42	PAINTING/WALLCOVERING	1999	5,981						42
43	VERSAMATIC-EC	1999	1,078						43
44	WALLCOVERING	1999	271						44
45	BUILDING DECORATIONS & FREIGHT	1999	2,453						45
46	ROOFING	1999	2,290						46
47	STRIP AND INSTALL NEW TILE	1999	3,400						47
48	EXHUAST FAN	1999	1,100						48
49	FREIGHT ON CARPET	1999	100						49
50	FIRE DOOR CLOSURES/RM DOORS	1999	2,307						50
51	WALLCOVERING	1999	5,356						51
52	INSTALL VAPOR FIXTURE IN LOT	1999	455						52
53	MOTION DETECTOR FOR ELEVATOR	1999	4,200						53
54	CARPET/PAINT	2000	63,699						54
55	PAINTING, WALLCOVERING, BORDERS	2000	1,705						55
56	EXHAUST FAN	2000	456						56
57	ROOF ACCESS LADDER	2000	3,940						57
58	DOOR CLOSER REPLACEMENT	2000	1,071						58
59	FLOORING IN DISHWASH AREA	2000	5,800						59
60	OUTDOOR LIGHTING	2000	3,985						60
61	WARFROBE CLOSET DOORS - ARCADIA UNIT	2000	4,675						61
62	PAINTING	2000	5,820						62
63	LIGHT FIXTURES	2000	3,640						63
64	PLUMBING FOR DISHWASHER	2000	5,361						64
65	STIAILESS STEEL FOR DISHRM	2000	1,000						65
66	CARPET	2000	12,605						66
67	WALLCOVERING	2000	9,801						67
68	FASCIA	2000	4,505						68
69	FLOORING/CARPET	2001	13,124						69
70	TOTAL (lines 4 thru 69)		$ 6,962,419	$ 282,217		$ 282,217	$	$ 2,635,079	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Palos Heights # 0033324 Report Period Beginning: 06/01/00 Ending: 05/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,962,419	$ 282,217		$ 282,217	$	$ 2,635,079	1
2	VALANCES AND MINI BLINDS	2001	3,151						2
3	CONSULTINING FEES	2001	3,720						3
4	HVAC	2001	2,716						4
5	WALLCOVERING	2001	9,122						5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,981,128	$ 282,217		$ 282,217	$	$ 2,635,079	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Palos Heights # 0033324 Report Period Beginning: 06/01/00 Ending: 05/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 860,691	$ 90,776	$ 90,776	$		$ 604,906	71
72	Current Year Purchases	52,669						72
73	Fully Depreciated Assets							73
74	Home Office Allocation			54,516	54,516			74
75	TOTALS	$ 913,360	$ 90,776	$ 145,292	$ 54,516		$ 604,906	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENTS	1995 GOSHEN GCII	1995	$ 17,000	$ 283	$ 283	$	5	$ 17,000	76
77		PARATRANSIT								77
78										78
79										79
80	TOTALS			$ 17,000	$ 283	$ 283	$		$ 17,000	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,511,679	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 373,276	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 427,792	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 54,516	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,256,985	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 21,879 Description: O2 Concentrators, Wheelchairs, Gerichairs, Elct. Beds, Etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Manorcare at Palos Heights # 0033324 Report Period Beginning: 06/01/00 Ending: 05/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	1867 hrs	$ 52,288		$	$ 544	1,867	$ 52,832	1
2	Licensed Speech and Language Development Therapist	10a	2130 hrs	55,538	50	1,220		2,180	56,758	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	2315 hrs	62,318	3	72	218	2,318	62,608	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				211,947		211,947	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): X-ray & Lab	39,3					42,619		42,619	13
14	TOTAL			$ 170,144	53	$ 1,292	$ 255,328	6,365	$ 426,764	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Palos Heights # 0033324 **Report Period Beginning:** 06/01/00 **Ending:** 05/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 05/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 47,937	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (208,189))	1,093,077		3
4	Supply Inventory (priced at)	15,243		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,044		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,161,301	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	600,191		13
14	Buildings, at Historical Cost	6,981,128		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	930,360		16
17	Accumulated Depreciation (book methods)	(3,256,984)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,254,695	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,415,996	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 37,160	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	333,409		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	447,304		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Trade Payable & Liabilities	92,859		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 910,732	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 910,732	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,505,264	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,415,996	$	48

***(See instructions.)**

Facility Name & ID Number Manorcare at Palos Heights # 0033324 Report Period Beginning: 06/01/00 Ending: 05/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,543,707	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,543,707	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,916,212	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 2,916,212	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(2,954,655)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (2,954,655)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,505,264	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,649,333	1
2	Discounts and Allowances for all Levels	(935,332)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,714,001	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,003,503	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,003,503	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,628	12
13	Barber and Beauty Care	48,976	13
14	Non-Patient Meals	318	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	202,669	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	23,188	19
20	Radiology and X-Ray		20
21	Other Medical Services	200	21
22	Laundry	14,697	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 292,676	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income	278	28
28a	Late charges	12,146	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 12,424	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,022,604	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,133,112	31
32	Health Care	3,027,992	32
33	General Administration	1,842,491	33
	B. Capital Expense		
34	Ownership	637,599	34
	C. Ancillary Expense		
35	Special Cost Centers	383,073	35
36	Provider Participation Fee	82,125	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,106,392	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,916,212	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,916,212	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	4,689	5,207	$ 141,103	$ 27.10	1
2	Assistant Director of Nursing	1,719	1,909	44,025	23.06	2
3	Registered Nurses	23,166	25,728	467,419	18.17	3
4	Licensed Practical Nurses	35,293	39,195	533,240	13.60	4
5	Nurse Aides & Orderlies	99,484	110,484	1,123,687	10.17	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	6,304	7,044	190,140	26.99	7
8	Rehab/Therapy Aides	5,127	5,730	106,110	18.52	8
9	Activity Director	7,480	8,310	88,414	10.64	9
10	Activity Assistants					10
11	Social Service Workers	1,936	2,150	29,066	13.52	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	33,096	37,013	327,272	8.84	15
16	Dishwashers					16
17	Maintenance Workers	2,936	3,268	47,945	14.67	17
18	Housekeepers	17,379	19,324	137,383	7.11	18
19	Laundry	6,227	6,914	47,320	6.84	19
20	Administrator	2,189	2,080	70,697	33.99	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,004	20,583	243,373	11.82	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,768	3,092	26,815	8.67	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	267,797	298,031	$ 3,624,009 *	$ 12.16	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	18,200	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	32,938	10a,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 51,138		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Tina Mitchell	Administrator	0%	$ 70,697
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 70,697

B. Administrative - Other

Description	Amount
Management Fees	$ 683,379
TOTAL (agree to Schedule V, line 17, col. 3)	$ 683,379
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
	Legal Fees	$ 1,506
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 1,506

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 78,361
Unemployment Compensation Insurance	25,724
FICA Taxes	268,810
Employee Health Insurance	221,004
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation	1,014
401K	25,439
Other Employee Benefits	48,318
Employee Vacines	316
Employee Uniforms	207
Home Office Allocation	(21,070)
TOTAL (agree to Schedule V, line 22, col.8)	$ 648,123

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 235
Advertising: Employee Recruitment	21,972
Health Care Worker Background Check	1,331
(Indicate # of checks performed 88)	
Dues & Subscriptions	50
Association Dues	6,801
Advertising	29,037
Public Relations	3,602
Less: Public Relations Expense	(3,602)
Non-allowable advertising	(29,037)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 30,389

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Includes travel expenses to the Home	3,382
Office in Toledo, OH for Regional meetings	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,382

* Attach copy of IMRF notifications

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Manorcare at Palos Heights # 0033324 Report Period Beginning: 06/01/00 Ending: 05/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $6801**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? _____

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **40,232** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **82,125**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **318**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **No**
Attach invoices and a summary of services for all architect and appraisal fees.